

State:	Arkansas	Filing Company:	United American Insurance Company
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other		
Product Name:	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D		
Project Name/Number:	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D /ARUAGDPC and ARUAGDP		

Filing at a Glance

Company:	United American Insurance Company
Product Name:	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	01/15/2013
SERFF Tr Num:	AMLC-128846401
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	ARUAGDPC AND ARUAGDP
Implementation	On Approval
Date Requested:	
Author(s):	Tom Cao
Reviewer(s):	Donna Lambert (primary), Rosalind Minor
Disposition Date:	01/30/2013
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

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General Information

Project Name: GROUP DRUG COVERAGE TO
SUPPLEMENT GROUP MEDICARE PART D

Status of Filing in Domicile: Pending

Project Number: ARUAGDPC and ARUAGDP

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer, Trust, Other

Explanation for Other Group Market Type: Union

Overall Rate Impact:

Filing Status Changed: 01/30/2013

State Status Changed: 01/30/2013

Deemer Date:

Created By: Tom Cao

Submitted By: Tom Cao

Corresponding Filing Tracking Number: ARUAGDPC and
ARUAGDP

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions:

No

Filing Description:

The policy form will be issued on an in-state or out-of-state basis to statutorily eligible groups including employer groups, labor unions, and non-discretionary trusts formed by such groups.

These forms will be used to underwrite health insurance benefits specifically designed for various Employer Groups, Unions and non - discretionary trusts formed by such groups. The benefit package is experience rated and will be fully negotiated with each group sponsor. We intend to develop rates on a group by group basis. The group policy will be issued to each individual group member.

This plan pays benefits as a secondary payor for services covered by Medicare Part D. Please note that although this coverage is designed to coordinate with Medicare Part D benefits, it is not Medicare Supplement insurance

Company and Contact

Filing Contact Information

Tom Cao, Compliance Analyst	tcao@torchmarkcorp.com
3700 S. Stonebridge Drive	214-544-5389 [Phone]
McKinney, TX 75070	972-569-3728 [FAX]

Filing Company Information

United American Insurance Company	CoCode: 92916	State of Domicile: Nebraska
P.O. Box 8080	Group Code: 290	Company Type: Life and Health
McKinney, TX 75070-8080	Group Name: Liberty National	State ID Number:
(972) 529-5085 ext. [Phone]	FEIN Number: 73-1128555	

State: Arkansas **Filing Company:** United American Insurance Company
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Product Name: GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D
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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50 per filing x 2 = \$100.
Per Company: No

Company	Amount	Date Processed	Transaction #
United American Insurance Company	\$100.00	01/15/2013	66568739

SERFF Tracking #:	AMLC-128846401	State Tracking #:		Company Tracking #:	ARUAGDPC AND ARUAGDP
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/30/2013	01/30/2013

SERFF Tracking #:	AMLC-128846401	State Tracking #:		Company Tracking #:	ARUAGDPC AND ARUAGDP
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Disposition

Disposition Date: 01/30/2013

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D CERTIFICATE	Approved-Closed	Yes
Form	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D POLICY	Approved-Closed	Yes

SERFF Tracking #:

AMLC-128846401

State Tracking #:

Company Tracking #:

ARUAGDPC AND ARUAGDP

State: Arkansas

Filing Company:

United American Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D

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Form Schedule

Lead Form Number: ARUAGDPC and ARUAGDP

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/30/2013	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D CERTIFICATE	ARUAGDP C	CER	Initial		49.210	ARUAGDPC.pdf
2	Approved-Closed 01/30/2013	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D POLICY	ARUAGDP	POL	Initial		54.400	ARUAGDP.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

NOTICE TO BUYER: This Certificate provides supplemental drug expense coverage but may not cover all of your drug expenses.

GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D

UNITED AMERICAN INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

The Insurer has issued Group Drug Policy No. [1234] to: [ABC Corporation] who shall be called the "Policyholder".

This Certificate establishes that You are insured for the benefits summarized in this Certificate, subject to all the terms of the Group Drug Policy under which this Certificate is issued.

This Certificate describes the benefits, important provisions, exclusions and limitations of Your coverage. Insurance under the Group Drug Policy is effective only if You become and remain insured. READ YOUR CERTIFICATE CAREFULLY. The Group Drug Policy may at any time be amended or discontinued by agreement between the Insurer and the Policyholder without your consent. Any such change will become effective on the effective date of the endorsement to the Group Drug Policy. The Group Drug Policy, unless stated otherwise in this Certificate, is governed by the laws of the State of issue.

30 DAY RIGHT TO EXAMINE CERTIFICATE

If You are not satisfied with this Certificate for any reason, return it to Our Administrative Offices or to Our designee within 30 days after You receive it. Any premium You paid will be refunded. The Certificate will be void from the beginning. It will be as if no Certificate had been issued.

RENEWAL PROVISION

The renewal premiums for this Certificate may change on the renewal date. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

We reserve the right to make a special adjustment to Our rates if, in Our opinion, Our liability has been altered because of a change in or operation of state or federal law, a revision to the Group Drug Policy requested by the Policyholder, or a substantive change in the composition of the lives covered under the Group Drug Policy. Any such change in rates will take effect on the effective date of the change in or operation of the law, the change to the Group Drug Policy, or the change in the composition of the lives covered under the Group Drug Policy.

CERTIFICATE SCHEDULE

INSURED	CERTIFICATE NUMBER	CERTIFICATE EFFECTIVE DATE
John Doe	000000	01-01-14
COMPANY [United American]	Coverage Supplemented: GROUP MEDICARE PART D PLAN [Group Name?]	[PLAN CODE] [XXX]

TABLE OF CONTENTS

	Page		Page
30 Day Right to Examine Certificate	1	Definitions	2
Renewal Provision	1	Certificate Provisions	3
Insuring Clause	2	Certificate Provisions - Claims	4
Persons Eligible for Coverage	2	Limitations and Exclusions	4
Enrollment and Effective Date of Your Coverage	2	Benefits for Covered Drugs	5

THE INSURING CLAUSE

The Insurer insures You against specified losses incurred by You. Benefits stated in this Certificate, subject to all its provisions, limitations and exclusions, will be paid for the losses which are incurred while Your coverage under the Group Drug Policy is in force.

PERSONS ELIGIBLE FOR COVERAGE

To be eligible for coverage under the Group Drug Policy, You must:

1. be a member of the group to which the Group Drug Policy was issued [or the Eligible Dependent];
2. be eligible for Medicare; and
3. be enrolled in the Group Medicare Part D Plan shown in the Certificate Schedule on Page 1 at all times while this Certificate is in effect.

ENROLLMENT AND EFFECTIVE DATE OF YOUR COVERAGE

ENROLLMENT

You may enroll [either] when you first become eligible for coverage under the Group Drug Policy [or during any open enrollment period].

EFFECTIVE DATE OF YOUR COVERAGE

The effective date of coverage for You shall be the Certificate Effective Date shown in the Certificate Schedule on Page 1.

Request for Change in Insured's Coverage:

If You request a change in Your coverage, the change will become effective upon Our agreement to the change provided that the required additional premium, if any, is paid.

If the request increases coverage, Our acceptance of the request will be subject to evidence of insurability.

DEFINITIONS

Where used in this Certificate:

ALLOWED DRUG COSTS means the ingredient cost, plus dispensing fee, plus sales tax charged by the pharmacy at the point of sale.

[CALENDAR YEAR] means the period which begins on each January 1ST and ends on the following December 31ST of the same year.]

CATASTROPHIC COVERAGE STAGE means the period each [CALENDAR or COVERAGE] YEAR after YOU have reached the TrOOP LIMIT through the end of such [CALENDAR or COVERAGE] YEAR.

CMS means Centers for Medicare & Medicaid Services, which is the Federal agency that administers MEDICARE.

COST SHARING means all amounts that YOU are obligated to pay, listed in the Member Cost Sharing Schedule, when a COVERED DRUG is received, before benefits are payable under the Group Drug Policy. This is in addition to the premium for YOUR Group Medicare Part D Plan and the Group Drug Policy. Cost Sharing is the total of the following: (1) any deductible amount; (2) any "copayment" amount; and (3) any "coinsurance" amount.

COVERAGE GAP STAGE means the period each [CALENDAR or COVERAGE] YEAR after the total of the ALLOWED DRUG COSTS for all COVERED DRUGS exceeds the ICL and before YOU reach the TrOOP LIMIT.

[COVERAGE YEAR] means the period which begins on [February 1ST], continues for the next [12] consecutive months, and ends on the following [January 31ST] of the [next] year.]

COVERED DRUG and COVERED DRUGS means any drug(s), prescribed for YOU by a PHYSICIAN, that is covered by Your Group Medicare Part D Plan shown in the Certificate Schedule on Page 1.

DEDUCTIBLE means the amount YOU are obligated to pay for COVERED DRUGS each [CALENDAR or COVERAGE] YEAR before WE will begin to pay a benefit under the Group Drug Policy.

ICL means Initial Coverage Limit as defined by CMS each year or, if modified, as stated in Your Group Medicare Part D Plan shown in the Certificate Schedule on Page 1.

INITIAL COVERAGE STAGE means the period each [CALENDAR or COVERAGE] YEAR after the total of the ALLOWED DRUG COSTS for all COVERED DRUGS reaches the Deductible, if any, and before the total of the ALLOWED DRUG COSTS for all COVERED DRUGS reaches the ICL.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

PHYSICIAN means a person duly licensed in the United States, operating within the scope of such license, and duly qualified to provide the care, treatment, services, or supplies for which the claim is made. Physician does not include YOU or any member of YOUR household or immediate family.

TrOOP LIMIT means the True Out-of-Pocket limit as defined by CMS each year. CMS determines what counts towards the TrOOP limit.

WE, US, OUR and INSURER mean the [United American] Insurance Company.

YOU, YOUR, YOURS and INSURED mean the person whose name is shown in the Certificate Schedule.

CERTIFICATE PROVISIONS

PREMIUM PAYMENT: This Certificate is issued, and Your coverage is effective, based on the enrollment form and the payment of the first monthly premium. A copy of the enrollment form is a part of this Certificate. Premium is due on the first day of each calendar month of coverage. This Certificate takes effect at 12:01A.M., Standard Time of the place where You reside on the Certificate Effective Date, shown in the Certificate Schedule on Page 1, and remains in effect until it is terminated pursuant to the Termination of Coverage provision. [All premiums, except the first premium shall be due and payable at Our Administrative Offices.].

[We may change any premium rate from time to time, subject to any required Insurance Department approval. If We change rates, notice will be given of the change as required by applicable state regulations.]

[Coverage will lapse on the last day of the period for which premium is paid or if the Group Drug Policy is terminated. If the premium is not paid by that date and the Policyholder has not given Us written notice that the Group Drug Policy is to be terminated, the grace period will begin.]

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the Certificate month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this Certificate provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

ENTIRE CONTRACT; CHANGES: The Group Drug Policy, with the Policyholder's application and attached papers, constitutes the entire contract between the Policyholder and the Insurer. Any statement made by the Policyholder or by an Insured shall be deemed a representation and not a warranty. No such statement by an Insured shall be used in defense of a claim for loss under the Certificate unless it is contained in a written application signed by the Insured.

No change in the Policy will be effective until approved by Us and endorsed by the Policyholder. No amendment, renewal or termination of the Group Drug Policy shall require the consent of any Insured or beneficiary or other person having a beneficial interest herein.

Our designee may not change this Certificate or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: Two years after the effective date of the Group Drug Policy, only fraudulent misstatements by the Policyholder shall be used to void the Policy. After two years from the Certificate Effective Date shown in the Certificate Schedule on Page 1, only fraudulent misstatements on Your enrollment form may be used to void Your coverage or deny any claim for loss incurred or disability that starts after the two year period.

GRACE PERIOD: This Certificate has a [2 month] grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following [2 months]. During the grace period this coverage will stay in force.

[REINSTATEMENT: If the renewal premium is not paid before the grace period ends, this Certificate will lapse. Later acceptance of the premium by Us (or by Our designee authorized to accept payment) without requiring an application for reinstatement will reinstate this Certificate subject to Persons Eligible for Coverage.

If We or Our designee requires an application, this Certificate will be reinstated when We approve the application, or on the 45th day after We receive it unless We have previously written You of its disapproval.

[The reinstated coverage will cover only loss that results from an Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Certificate.]]

TERMINATION OF COVERAGE: Your coverage will terminate at 12:01 A.M. on the first day of the calendar month on, or next following, the earliest of the following dates:

- 1) the date the Group Drug Policy is terminated;
- 2) the date the premium required to keep the coverage in force is not paid within the time allowed;
- 3) the date You cease to be eligible for this plan; or
- 4) the later of the date We receive written notice that You wish to terminate Your coverage or the termination date requested in the notice.

CERTIFICATE PROVISIONS-CLAIMS

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices in McKinney, Texas or to Our designee. Notice should include Your name and Your Certificate Number.

CLAIM FORMS: When We receive the notice of claim, We will send You any required forms for filing proof of loss, if applicable. If these forms are not given to You within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of Your loss.

PROOF OF LOSS: You must give written proof of loss to Us within 6 months after the date of such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, We will pay all benefits then due for such loss.

PAYMENT OF CLAIMS: Benefits will be paid, after receiving a claim form and proper written proof of loss satisfactory to Us, to You, or at Our option to the pharmacy, hospital, doctor, or person providing care, treatment, services, or supplies covered by this policy. Any benefit due and unpaid at death may be paid, at Our option, to Your estate. If benefits are payable to Your estate, We can pay benefits up to \$3,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

LEGAL ACTIONS: No legal action may be brought to recover on the Group Drug Policy within 60 days after written proof of loss has been given as required by the Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

CONFORMITY WITH STATE STATUTES: Any provision of this Certificate which, on its effective date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under the Certificate shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this Certificate for:

- 1) Any expense which You are not legally obligated to pay.
- 2) Any portion of any expense which is paid by the Federal government.
- 3) Any portion of any expense for which payment is made by Your Group Medicare Part D Plan shown in the Certificate Schedule on Page 1.
- 4) Any amount discounted by the drug manufacturer.
- 5) Any type of expense not eligible for coverage under Your Group Medicare Part D Plan shown in the Certificate Schedule on Page 1.

- 6) Any expense incurred before the Certificate Effective Date or after Your coverage under this Certificate terminates.
- 7) Any drugs dispensed by You or a member of Your household or immediate family.

SPECIMEN

BENEFITS FOR COVERED DRUGS

We will pay the ALLOWED DRUG COSTS for each COVERED DRUG received by YOU while this Certificate is in force less the total of (1), (2), and (3) below:

1. the applicable COST SHARING amount(s) listed in the Member Cost Sharing Schedule below; and
2. the amount payable by Your Group Medicare Part D Plan shown in the Certificate Schedule on Page 1; and
3. any amount payable by a drug manufacturer, the federal government (excluding any federal low income claim subsidy), or any other third party whose liability is primary to the Group Medicare Part D Plan.

[UNITED AMERICAN] GROUP MEDICARE PART D PLAN – [Plan Code] MEMBER COST SHARING SCHEDULE

[CALENDAR or COVERAGE] YEAR DEDUCTIBLE]
[\$100]

[INITIAL COVERAGE STAGE COST SHARING]

Retail Pharmacy

[Tier 1 label Preferred Generic]

- [\$5 copay for a one-month (34-day) supply of drugs in this tier]

- [\$10 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 2 label Non-Preferred Generic]

- [\$9 copay for a one-month (34-day) supply of drugs in this tier]

- [\$25 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 3 label Preferred Brand]

- [\$38 copay for a one-month (34-day) supply of drugs in this tier]

- [\$95 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 4 label Non-Preferred Brand]

- [\$76 copay for a one-month (34-day) supply of drugs in this tier]

- [\$190 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 5 label Specialty]

- [33% coinsurance for a one-month (34-day) supply of drugs in this tier]

- [33% coinsurance for a three-month (90-day) supply of drugs in this tier]

Mail Order

[Tier 1 label Preferred Generic]

- [\$10 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 2 label Non-Preferred Generic]

- [\$23 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 3 label Preferred Brand]

- [\$76 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 4 label Non-Preferred Brand]

- [\$152 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 5 label Specialty]

- [33% coinsurance for a three-month (90-day) supply of drugs in this tier]

[GAP STAGE COST SHARING]

Retail Pharmacy

[Tier 1 label Preferred Generic]

- [\$5 copay for a one-month (34-day) supply of drugs in this tier]

- [\$10 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 2 label Non-Preferred Generic]

- [\$9 copay for a one-month (34-day) supply of drugs in this tier]

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[Tier 2 label Non-Preferred Generic]

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[Tier 3 label Preferred Brand]

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[Tier 4 label Non-Preferred Brand]

- [\$152 copay for a three-month (90-day) supply of drugs in this tier]

[Tier 5 label Specialty]

- [33% coinsurance for a three-month (90-day) supply of drugs in this tier]

[CATASTROPHIC STAGE COST SHARING]

Retail Pharmacy

[Tier 1 label Preferred Generic]

- [\$5 copay for a one-month (34-day) supply of drugs in this tier]

- [\$10 copay for a three-month (90-day) supply of drugs in this tier]

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UNITED AMERICAN INSURANCE COMPANY
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

Group Policyholder: [ABC Corporation]

Group Policy Number: [1234]

Effective Date of the Group Policy: [January 01, 2014]

State of Issue: [Arkansas]

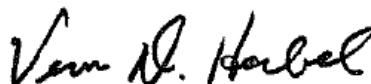
This Group Drug Policy contains the terms under which the United American Insurance Company agrees to insure certain Group members and pay benefits in consideration for the application and payment of the premium. The Group Drug Policy takes effect on the Effective Date of the Group Policy shown above. It continues as long as the required premiums are paid, except as described in the Payment of Premiums Provision.

The Insurance Company and the Policyholder have agreed to all of the terms of this Group Drug Policy.

Signed by officers of the United American Insurance Company at McKinney, Texas.



Secretary



President

**GROUP DRUG POLICY TO SUPPLEMENT GROUP MEDICARE PART D
NON-PARTICIPATING**

PREMIUMS

PAYMENT OF PREMIUMS

The first premium is due on the Effective Date of the Group Policy. Each following premium payment is due monthly unless we agree with the Policyholder on some other method of payment. We may also agree with the Policyholder to change the amount of premium payment and its effective date of change. Premium payments should be sent to Our Administrative Office. Premiums will be considered paid on the date We receive the payment at Our Administrative Office or other designated location.

Premium is due on the first day of each month. A grace period of 2 months is allowed for the late payment of each premium after the first premium. If the Policyholder has not given Us written notice that the Group Drug Policy is to be terminated prior to the premium date, the grace period for payment will begin. If the premium is paid by the end of the grace period, the Group Drug Policy will remain in force. If the premium is not paid by the end of the grace period, the Group Drug Policy automatically terminates effective as of the last day of the month for which the last premium payment was received. Any claims incurred after the last day of the month for which premium was received are the responsibility of the Policyholder.

[Premiums withheld from Insured's shall not cause coverage for such Insured's to be or remain in effect, if premiums are not paid on time, as provided above. The Policyholder, in collecting these premiums, is acting for the Insured's and not for the Insurer.

The Group Drug Policy premiums are to be paid to Us by the Policyholder. However, they may be paid to Us by any other person according to a Mutual agreement among the other person, the Policyholder and Us.]

[PREMIUM STATEMENT

A premium statement will be prepared in accordance with the billing method We arrange with the Policyholder. This premium statement will show the premium due. It will also reflect any pro rata premium charges and credits resulting from changes in the number of insured persons and changes in the amounts of insurance that took place during the period following the last premium statement. In the event that notice of termination of an insured person, or a decrease in coverage, is received by Us more than one month after the termination or decrease, retroactive premium credit will be limited to one month's premium.]

CHANGE IN PREMIUMS

We reserve the right to make a special adjustment to Our rates if, in Our opinion, Our liability has been altered because of a change in, or operation of, state or federal law, a revision to the Group Drug Policy requested by the Policyholder, or a substantive change in the composition of the group. Any such change in rates will take effect on the effective date of the change in, or operation of, the law, the change in benefits, or the change in the composition of the group. A rate adjustment made for any of the reasons stated above will supersede any rate guarantee, if any, previously agreed to.

TERMINATION FOR THE GROUP DRUG POLICY

TERM OF POLICY AND RENEWAL PRIVILEGE

The Group Drug Policy begins on the Effective Date of the Group Policy. It will continue for as long as premiums are paid or until it is terminated. Notice to terminate the Group Drug Policy can come from either the Policyholder or from Us. The Policyholder may terminate any or all of the insurance by giving us written notice. It will terminate on the later of:

1. the date requested in the termination notice; or
2. the date we receive the notice.

The Insurer may cancel the Group Drug Policy at any time by giving written notice to the Policyholder of the date the Group Drug Policy is to be canceled. The notice will be delivered or mailed to the Policyholder at the address shown on the Insurer's records in accordance with applicable state regulations.

REQUIRED DATA

The Policyholder will provide the Insurer with all data needed to carry out the terms of the Group Drug Policy, including, but not limited to: (1) details of persons who become insured; (2) changes in the amount of insurance; (3) termination of insurance; and (4) any other information the Insurer may reasonably require. The relevant records of the Policyholder may be inspected by the Insurer at any time.

CERTIFICATE PROVISIONS MADE A PART OF THE GROUP DRUG POLICY

The remainder of the Group Drug Policy consists of the provisions shown in the Certificate(s) issued to Insured's under the Group Drug Policy. These provisions, described in general below, are made a part of the Group Drug Policy.

Amendments, if any, changing the provisions of the Certificate are also made a part of the Group Drug Policy.

Certificate Face Page
Table of Contents
Definitions
Eligibility and Effective Dates
Benefit Provisions
Termination Provisions

SERFF Tracking #:	AMLC-128846401	State Tracking #:		Company Tracking #:	ARUAGDPC AND ARUAGDP
State:	Arkansas	Filing Company:	United American Insurance Company		
TOI/Sub-TOI:	H21 Health - Other/H21.000 Health - Other				
Product Name:	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D				
Project Name/Number:	GROUP DRUG COVERAGE TO SUPPLEMENT GROUP MEDICARE PART D /ARUAGDPC and ARUAGDP				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
Readability Certification - AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
ARUEGRUAP.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/30/2013
Bypass Reason:	N/A, this is a group retiree health filing.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/30/2013
Bypass Reason:	N/A, this a group retiree health policy.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/30/2013
Bypass Reason:	N/A, this is not a major medical filing.		

UNITED AMERICAN INSURANCE COMPANY

McKinney, Texas

READABILITY CERTIFICATION

We hereby certify we have carefully reviewed the form(s) listed below and to the best of our knowledge and ability determine the Flesch scale analysis readability test score to be as shown:

<u>FORM</u>	<u>SCORE</u>
Group Drug Coverage to Supplement Group Medicare Part D Certificate - ARUAGDPC	49.21
Group Drug Coverage to Supplement Group Medicare Part D Policy - ARUAGDP	54.40

Date: January 15, 2013



Michael J. Gaisbauer, Vice President

FORM S-1351

UNITED AMERICAN INSURANCE COMPANY

P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Legal Reserve Stock Company * Administrative Offices: McKinney, Texas

APPLICATION

1. a. Group Policy Number: [1234]
b. Policyholder: [ABC Corporation]
2. Group Effective Date: [January 25, 2010]
3. Eligible Member of the Group: [Members of ABC Corporation]
4. Eligible Dependents: [The spouse or surviving spouse of a Group Member,] [the spouse of an active employee of the Policyholder,] [the spouse of an early retiree of the Policyholder,] [the widow or widower of a Group Member whose rights are continued under the Policyholder's retirement plan,] or [the divorced spouse of a Group Member whose rights are continued under the Policyholder's retirement plan].

The Applicant hereby applies for Group Insurance and understands and agrees that insurance applied for shall not become effective until the application for Group Insurance is approved by United American Insurance Company at its Administrative Office.

This application, as it may be amended, will become a part of the Group Policy if issued.

FOR THE POLICYHOLDER:

Signed by	_____	Title	_____
Signed at	_____	Date	_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARUEGRUAP